COVID-19 VACCINE MEDICAL EXEMPTION REQUEST

Name: _____ SJSU ID: _____

Date of Birth: _____ Date: _____

I am a: ☐ Student ☐ Employee

I, _____ (Name of licensed MD, DO, PA NP)

hereby certify that the above-name student/employee has:

☐ A medical condition that contraindicates this individual's vaccination with a COVID-19 vaccine.

Please check the appropriate box and list below either:

a) ☐ The applicable CDC contraindicates to this vaccine,* or

b) ☐ The applicable manufacturer's vaccine insert contraindication to this vaccine,* or

c) ☐ The physical condition of the person or medical circumstances relating to the person that are such that immunization is not considered safe, indicating the specific nature of the medical condition or circumstances* that contraindicate immunization with this vaccine*

***REQUIRED**: Description of contraindication meeting criteria a, b, or c above

This contraindication is: ☐ Permanent or ☐ Temporary

If Temporary, expiration date of the exemption for this vaccine is:

Signature of Medical Provider | Date | Medical License Number & State/Country of Issue

Return this completed form to University Personnel either Online or by Email.

- Online: SJSU @ Work
- Email: up-vaccine-mgmt@sjsu.edu

For Use by San José State Student Health & Counseling Staff Only:		
Date Approved:	Date Denied:	Date of Entry to SJSU @ Work: